Dr KS Sivananthan v The Government of Malaysia & Anor

HIGH COURT (IPOH) — CIVIL APPEAL NO 12–27–1996
PS GILL J
27 MARCH 2000

Tort *— Negligence — Professional negligence — Medical practitioner — Causation — — Contributory negligence — Plaintiff's leg amputated — Plaintiff treated earlier by another doctor — Whether causative link between resultant damage and negligent act*

Tort *— Negligence — Professional negligence — Medical practitioner — Standard of care — — Advance stage of ischaemia — Amputation — Failure to maintain circulation chart and give proper advice upon discharge — Whether contributory negligence*

Evidence *— Expert evidence — Medical opinion — Opinion on matters outside field of expertise — Whether medical expert may give evidence regarding handwriting and authenticity of medical records*

The plaintiff was involved in a motor vehicle accident on 4 September 1983 and fractured his right leg. He was admitted to Ipoh General Hospital ('GH') on the same day where a full length plaster of paris ('POP') was applied to his leg. He remained at GH until the next day when he decided to discharge himself at his own risk. He then admitted himself to Fatimah Hospital at Ipoh ('FH') on the same day (5 September 1983). He was attended to by the appellant who immediately split the POP and did an operative procedure (fasciotomy) on the plaintiff's leg. On 12 September 1983, he put an internal fixator in the plaintiff's leg. However, on 3 June 1984 the plaintiff's leg was amputated as the leg could not be saved. The issue before the trial court was in respect of the apportionment of the liability of the respondents as the third party and the appellant as the fourth party to the damages awarded to the plaintiff. At the end of the trial the judge found both the third party and fourth party negligent and apportioned their contribution at 60% for the third party respondents and 40% for the fourth party appellant. The appellant appealed. The question before this court was whether the appellant and the respondents were both negligent in their treatment of the plaintiff and if so whether liability should have been apportioned in the manner as determined by the trial judge.

Held, allowing the appeal:

(1) It would appear from the facts of the case that the respondents had failed to maintain the circulation chart properly and to provide the necessary care to the plaintiff when the plaintiff needed it. If the chart had been maintained properly, timely action could have been taken in the early stages of the problem. Clearly the staff at GH did not provide any fair and reasonable care to the plaintiff. The respondents were also negligent in failing

to give any proper advice to the plaintiff upon his discharge from the hospital. In fact at the time of discharge, the respondents should have given the plaintiff immediate medical treatment because the plaintiff's leg was then at least in a state of fairly advanced ischaemia (see pp 41F–G, I, 42C).

(2) Based on the reading of the circulation chart and evidence of medical experts, when the plaintiff was first attended to by the appellant, his leg was already at a severe level of ischaemia with some irreversible damage. This was in contrast to the finding of the trial judge who made a finding that the plaintiff was only at a fairly advanced ischaemic condition when the plaintiff arrived at FH. This finding was erroneous (see p 43E–F).

(3) An expert should not give an opinion on matters outside his field of expertise. Clearly the evidence of the medical experts regarding handwriting and authenticity of the records were not admissible evidence and should not have been accepted by the trial judge. As such, the trial judge was in error in making the finding that the fasciotomy was done on 12 September 1983 and not on 5 September 1983 (see p 44D–E).

(4) A doctor is not negligent if he is acting in accordance to a practice accepted as proper by a responsible body of medical men skilled in that particular art merely because there is a body of opinion that takes a contrary view. Thus, the decision by the appellant to do an internal fixation on the plaintiff's leg by itself was not negligent (see p 45D–E); *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 followed.

(5) The onus was on the respondents to show on the balance of probabilities that there was a causative link between the resultant damage and the negligent act of the appellant. The trial judge apparently failed to direct his mind to the issue of causation. He erred in failing to appreciate the true extent of the plaintiff's condition on arrival at FH. As such, if the appellant was found liable, his liability should have been apportioned lower. Having said that, taking this findings of the judge to be correct, it would still appear to amount to a conclusion that the respondents had failed to prove causation on a balance of probabilities. This apportionment of liability on the appellant would have meant that the respondents had failed to prove that the plaintiff would have recovered even if he had received proper treatment from the appellant (see p 46C, 47A, C–D).

(6) The appellant should not have been found negligent and the issue of quantification of contribution should not have arisen. Thus, the appellant was absolved from all liability to the plaintiff and the respondents were therefore fully responsible for the plaintiff's damages (see p 48F–G).

[Bahasa Malaysia summary

Plaintif terlibat di dalam kemalangan kenderaan motor pada 4 September 1983 dan kaki kanannya telah patah. Beliau telah dimasukkan ke Hospital Besar Ipoh ('GH') pada hari sama di mana balutan panjang Paris yang penuh ('POP') telah dibalut di atas kakinya. Beliau tinggal di GH sehingga keesokan hari apabila beliau keluar dari hospital dengan risikonya sendiri. Kemudian beliau menerima rawatan di Hospital Fatimah di Ipoh ('FH') pada hari yang sama (5 September 1983). Beliau telah dirawat oleh perayu yang dengan segera memotong POP tersebut dan melakukan prosedur pembedahan (fasciotomy) ke atas kaki plaintif. Pada 12 September 1983, beliau telah masukkan fixator ke dalam kaki plaintif. Namun, pada 3 Jun 1984 kaki plaintif terpaksa dipotong kerana kaki tersebut tidak boleh diselamatkan. Isu di hadapan mahkamah adalah berkenaan dengan pembahagian tanggungan responden-responden sebagai pihak ketiga dan perayu sebagai pihak yang keempat terhadap ganti rugi yang diawardkan kepada plaintif. Pada akhir perbicaraan, hakim mendapati kedua-dua pihak ketiga dan pihak keempat cuai dan membahagikan sumbangan mereka pada 60% untuk responden pihak ketiga dan 40% untuk pihak perayu keempat. Perayu telah merayu. Persoalan di hadapan mahkamah adalah sama ada perayu dan responden-responden adalah kedua-duanya cuai di dalam memberikan rawatan kepada plaintif dan jika ada sama ada tanggungan sepatutnya dibahagikan dengan cara yang ditentukan oleh hakim perbicaraan.

Diputuskan, membenarkan rayuan tersebut:

(1) Adalah jelas daripada fakta-fakta kes bahawa responden-responden telah gagal untuk mengekalkan carta prestasi dengan betul dan memberikan perhatian yang sewajar kepada plaintif apabila plaintif memerlukannya. Jika carta dikekalkan dengan baik, tindakan pada masa tersebut boleh diambil pada peringkat awal masalah tersebut. Dengan jelas, kakitangan di GH tidak memperuntukkan perhatian yang munasabah dan baik kepada plaintif. Responden-responden juga adalah cuai kerana gagal memberikan nasihat yang sewajarnya kepada plaintif selepas dilepaskan dari hospital. Malah pada masa pelepasan, responden-responden sepatutnya memberikan plaintif rawatan perubatan yang segera kerana kaki plaintif adalah sekurang-kurangnya di dalam keadaan ischaemia yang teruk (lihat ms 41F–G, I, 42C).

(2) Berdasarkan carta prestasi dan keterangan saksi-saksi perubatan, apabila plaintif dirawat buat pertama kali oleh perayu, kakinya sudah berada dalam peringkat ischaemia yang buruk dengan kecederaan yang tidak boleh pulih semula. Ini adalah bercanggah dengan penemuan hakim perbicaraan yang membuat penemuan bahawa plantif dalam keadaan ischaemic yang agak teruk sahaja

apabila plaintif tiba di FH. Penemuan tersebut adalah silap (lihat ms 43E–F).

(3) Seorang pakar tidak sepatutnya memberikan pendapat berkenaan perkara-perkara di luar kepakarannya. Dengan jelas, keterangan pakar perubatan berkenaan dengan tulisan dan kebenaran rekod-rekod tidak boleh diterima sebagai keterangan dan tidak sepatutnya diterima oleh hakim perbicaraan. Dengan demikian, hakim perbicaraan adalah silap di dalam membuat penemuan bahawa fasciotomy telah dibuat pada 12 September 1983 dan bukannya 5 September 1983 (lihat ms 44D–E).

(4) Seorang doktor bukanlah cuai apabila beliau bertindak menurut amalan yang diterima sebagai wajar oleh badan ahli perubatan yang bertanggungjawab yang mahir dalam bidang tertentu, semata-mata kerana terdapat pendapat berlainan yang mengambil pendapat yang berbeza. Dengan itu, keputusan perayu untuk membuat fixation ke atas plaintif dengan sendiri bukanlah cuai (lihat ms 45D–E, H); *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 diikut.

(5) Beban adalah di atas responden untuk menunjukkan di atas imbangan kebarangkalian bahawa terdapat hubungan akibat antara kerosakan yang diakibatkan dan tindakan cuai perayu tersebut. Hakim perbicaraan dengan jelas gagal mengarahkan mindanya kepada isu penyebaban. Beliau silap kerana gagal untuk menilai takat sebenar keadaan plaintif pada masa ketibaan di FH. Oleh demikian, jika perayu didapati bertanggungan, liabilitinya sepatutnya dibahagikan lebih rendah. Selepas memutuskan begini, mengambil penemuan-penemuan hakim sebagai betul, adalah masih jelas untuk terjumlah kepada kesimpulan bahawa responden-responden telah gagal untuk membuktikan penyebaban (causation) di atas imbangan kebarangkalian. Pembahagian tanggungan tersebut ke atas perayu bermaksud bahawa responden-responden gagal untuk membuktikan bahawa plaintif akan sembuh walaupun beliau menerima rawatan yang sewajar daripada perayu (lihat ms 46C, 47A, C–D).

(6) Perayu tidak sepatutnya didapati cuai dan isu pengiraan sumbangan tidak patut timbul. Dengan itu, perayu dibebaskan daripada semua tanggungan terhadap plaintif dan responden-responden adalah bertanggungjawab sepenuhnya untuk ganti rugi plaintif (lihat ms 48F–G).]

Notes

For cases on medical opinion, see 7 *Mallal's Digest* (4th Ed, 1998 Reissue) paras 1182–1183.

For cases on medical practitioner generally, see 12 *Mallal's Digest* (4th Ed, 2000 Reissue) paras 827–844.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (folld)
Christopher Rogers v Maree Lynette Whitaker [1993] 1 CLJ 449 (refd)
Dato Mokhtar bin Hashim & Anor v PP [1983] 2 MLJ 232 (refd)
Hotson v East Berkshire Area Health Authority [1987] 2 All ER 909 (refd)
Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128 (refd)
Maynard v West Midlands RHA (HL) [1984] WLR 634 (refd)
PP v Lin Lian Chen [1991] 1 MLJ 316 (refd)
Wilsher v Essex Area Health Authority [1988] 1 All ER 871 (refd)

Legislation referred to

Civil Law Act 1956 s 10(c)

Appeal from: Summons No 53–358–89 (Sessions Court, Ipoh)

PS Ranjan (*PS Ranjan & Co*) for the appellant.
Shahidani bin Abdul Aziz for the respondents.

PS Gill J. : The plaintiff was involved in a motor vehicle accident on 4 September 1983 at about 5.00 am. He was admitted to Ipoh General Hospital ('GH') at about 5.45 am the same day. He sustained a 2cm lacerated wound over his right eyebrow and a fractured upper third of the right tibia. At GH, his wound was treated and a full length plaster of paris (POP) was applied to his leg. He remained at GH until 9.45 am the next day. The plaintiff, apparently dissatisfied with the care he received, decided to discharge himself at his own risk ('AOR'). He then admitted himself to Fatimah Hospital in Ipoh ('FH') on the same day (ie 5 September 1983) at about 12.00 noon. He was attended to by the appellant, Dr Sivananthan. The appellant apparently, immediately split the POP and did an operative procedure called fasciotomy on the plaintiff's leg. On 12 September 1983, he put an internal fixator in the plaintiff's leg to treat the fracture. After that, the plaintiff was treated as an outpatient. However, on 3 June 1984 the plaintiff's leg was amputated below the knee as the leg could not be saved.

The plaintiff brought an action in tort against the defendant on 17 September 1984 for causing the accident. On 21 March 1986, the defendant was allowed to commence third party proceedings against the respondents for contribution to the damages claimed by the plaintiff. The third party/respondent, in turn, was allowed to bring a fourth party action against the appellant for contribution to the cause of the plaintiff's damages.

Before the trial commenced, the parties agreed that the plaintiff be awarded an agreed sum of RM80,000 for special and general damages. Further the defendant's liability for the plaintiff's damages was fixed at 90%. The issue before the trial court was in respect of the apportionment of the liability of the respondents as the third party, and the appellant as the fourth party to the damages awarded to the plaintiff. At the end of the trial, the learned sessions court judge found both the third party and fourth party

negligent and apportioned their contribution at 60% for the third party respondents and 40% for the Fourth Party appellant.

The question before this court is whether the appellant and the respondents were both negligent in their treatment of the plaintiff and if so, whether liability should have been apportioned in the manner as determined by the learned trial judge.

Treatment at Ipoh General Hospital (GH)

Upon admission to GH at 5.45 am on 4 September 1983, the plaintiff was treated for the lacerated wound before he was warded. An x-ray was later taken and it showed that the plaintiff had a spiral fracture at the upper third of the tibia and fibula. At 5.00 pm the same day, a full length plaster of paris ('POP') was applied to his leg. The doctor then ordered a circulation chart to be maintained hourly to record the colour, sensation, and movements of the toes. These observations were necessary to monitor the blood circulation of the leg. This is very important because if the POP applied was too tight, it might result in the blood circulation in the leg being blocked and a medical condition known as ischaemia would set in. Once ischaemia has set in and the condition is left untreated, it would become irreversible which may lead to necrosis of the muscles and the leg would have to be amputated. The court was told that irreversible ischaemia would set in as early as six hours after the circulation is completely obstructed but it may extend to 8–12 hours, depending on the extent of the blockage. The signs of severe ischaemia are severe pain, colour of toes being bluish or plum, and there will be no pulse, parathesis, and paralysis of the muscles. These observations are thus very important. Should there be any symptoms observed, immediate medical attention is required.

The maintenance of the circulation chart was done hourly from 5.00 pm on 4 September 1983. The nurses on duty admitted that the chart was only maintained until 11.00 pm that night. No observations were done after that until 8.20 am the next morning. At 11.00 pm on 4 September 1983 the reading on the circulation chart was:

> … toe pink and warm, sensation felt and able to move all toes.

The condition of the plaintiff's leg seems normal as there was no sign of ischaemia then.

However, at 8.20 am the next morning, the reading which was taken by another assistant nurse was:

> … pink and slightly cold, sensation not felt, slightly able to move all toes.

This same reading was recorded an hour later at 9.20 am. It is apparent the condition of the plaintiff's leg has worsened as there were then signs that ischaemia has set in. In fact both the respondent's medical experts agreed that this is so. TPW2 Dato' Dr Sivananthan said that the plaintiff's leg then was probably in the 'early stages of ischaemia', whereas TPW3, Dr Merican Mahmood said that in his opinion, the plaintiff's leg was then a case of 'fairly advanced ischaemia.'

The standard procedure to be taken when signs of ischaemia are detected is to split open the POP and to watch for signs of improvement. If the condition does not improve, an operative procedure called fasciotomy would have to be performed. Unfortunately, all these procedures were not done at GH.

The law on medical negligence as stated by the Federal Court in *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128 at p 129, is as follows:

> A doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, ie the skill of an ordinarily competent medical practitioner.

In that case, where the material facts were almost identical to the present case, Salleh Abas FJ (as he then was), delivering the judgment of the court at p 130 said:

> ... the application of POP long boot to the respondent's left leg is not in itself a negligent act. However, since the application of POP carries with it an inherent danger to blood circulation, the question is whether there was a fair and reasonable standard of care taken after POP was applied to see that there would be no problem of blood circulation. If there was such a standard of care, Dr Susila and the government would not be liable, but if there was not, they would be liable and the damages awarded should be apportioned.

Further, His Lordship added at p 131:

> Thus, in our view, the evidence in this case clearly shows that the respondent was not given a fair and reasonable standard of care and skill expected of an ordinarily competent medical practitioner. The breach of care here consists of lack of proper skill in the application of the treatment and lack of proper observation in monitoring the patient's response to the treatment after it was given, so that by the time the hospital came to realize that something was wrong it was already too late.

It would appear from the facts of the case that the respondents have failed to maintain the circulation chart properly and to provide the necessary care to the plaintiff when the plaintiff needed it. If the chart had been maintained properly, timely action could have been taken in the early stages of the problem. Upon taking the reading at 8.20 am on 5 September 1983, the assistant nurse should have alerted the doctor with regard to the condition of the plaintiff's leg so that remedial action could be taken. All these were not done. Clearly, the staff at GH did not provide any fair and reasonable care to the plaintiff.

The respondents had subsequently discharged the plaintiff, albeit at his own risk (AOR), at 9.45 am that morning. No medical advice or warning, was given to the plaintiff or his brother as to the risk he may be taking. It was not disputed that it is the hospital's duty to do so, and the failure to give any advice to the patient in the circumstances is contrary to its practice. In fact, no evidence was adduced to indicate that the plaintiff was ever attended to or seen by any medical doctor that morning before he was discharged. Thus, the respondents were also negligent in failing to give any proper advice to the plaintiff upon his discharge from the hospital.

In the case of *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 449 the Australian High Court said:

> This standard of skill is however not determined solely or primarily by the practice of the relevant profession or trade. Due consideration must also be given to the fact that a person is entitled to make his own decisions about his life. As regards the duty of disclosure of facts and risks involved, a patient is entitled to know what risks are involved in undergoing or foregoing the surgery or other treatment. Whether or not a doctor is in breach of the requisite standard of care varies according to diagnosis, treatment or the provision of information or advice. It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, consider it to be significant.

In fact, at the time of the discharge, the respondents should have given the plaintiff immediate medical treatment because the plaintiff's leg was then, at least, in a state of fairly advanced ischaemia. As the assistant nurse had noted the condition at 8.20 am on 5 September 1983, she should have immediately informed the doctor on duty about it. The POP should have been split immediately. It was at this moment when the plaintiff most needed the care and attention of the respondents, and yet nothing was done. Instead, the appellant was allowed to be discharged without the benefit of knowing the risks involved.

Treatment at Fatimah Hospital, Ipoh (FH)

Upon discharge from GH, the plaintiff had sought treatment at FH. He was first attended to by the appellant at the casualty room at about 12.00 noon that day (5 September 1983). The appellant said that after observing the plaintiff's condition, he immediately split the POP and performed a fasciotomy on the plaintiff's leg in the casualty room without using any anesthesia. He explained that the plaintiff's condition required immediate treatment and it would take too long to get the operation theater ready. On 12 September 1983, the appellant performed an extended fasciotomy and did an internal fixation to fix the fracture on the plaintiff's leg. Thereafter, the appellant continued treating the plaintiff as an outpatient and subsequently on 3 June 1984, he did a below knee amputation of the plaintiff's leg. The leg muscles had become necrotic and the leg could not be saved.

The respondents contented that the appellant was negligent in treating the plaintiff which led to the amputation of the plaintiff's leg. They asserted that the appellant was negligent:

(a) in delaying the performance of fasciotomy on the plaintiff's leg; and

(b) in deciding to put an internal fixator to treat the fracture in the plaintiff's leg.

The delay in performing fasciotomy

To determine this issue, it is necessary to make a finding of the condition of the plaintiff's leg when he was first admitted to FH. When the plaintiff was

brought to FH at about 12.00 noon on 5 September 1983, the appellant made the following observation of the plaintiff's leg. It reads:

> … toes swollen, no sensation and unable to move his toes.

This observation was never challenged by the respondents. Based on this observation, the plaintiff's condition seemed to have worsened from the 'fairly advanced ischaemia'condition when he was at GH. The appellant contented that the plaintiff's leg then was at a 'severe level of ischaemia' when he arrived at FH. This contention was supported by his medical witness, FPW2, Prof Balasubramaniam. The appellant further contented that the plaintiff's leg has already suffered irreversible damage. The use of the leg could not be recovered because it has become anesthetic and a major portion of its muscles, being necrotic, had to be removed. In fact, amputation was suggested to the plaintiff on 26 September 1983, about three weeks after admission.

It is clear that the plaintiff's leg had developed ischaemia overnight. As the reading on the circulation chart taken at 11.00 pm on 4 September 1983 showed that the condition of the plaintiff's leg was normal, it could be inferred that the ischaemic condition had started sometime between 11.00 pm on 4 September 1983 and 8.20 am on 5 September 1983. It is pertinent to note that by the time the plaintiff was attended to by Dr Siva, his condition could have been left untreated for more than 12 hours since the onset of ischaemia. According to the medical experts, this would have resulted in some irreversible damage to the leg.

Thus, when the plaintiff was first attended to by the appellant, his leg was already at a severe level of ischaemia with some irreversible damage. This is in contrast to the finding of the learned trial judge who made a finding that the plaintiff's leg was only at a fairly advanced ischaemic condition when the plaintiff arrived at FH. As explained above, this finding is erroneous.

The respondents had further alleged that based on the records at FH, which was tendered in court, it could be inferred that the fasciotomy was only done on 12 September 1983 and not on 5 September 1983, as stated by the appellant. It was the contention of the respondents that this delay by the appellant in performing the operative procedure had contributed to the plaintiff's damage. They explained that this was because there was no record of consent given by the plaintiff for this operative procedure on 5 September 1983, and that there was no mention of decompression or fasciotomy done on 5 September 1983 in the medical report (exh AB II) prepared by the appellant for the plaintiff's solicitors. This is further compounded by the fact that there was no entry in the operating theater record that showed that the operation was done that day. Further, they argued that if the operation was done on 5 September 1983, why then was there no record of any directive given to the nurses to note the condition of the leg muscles, and why was there no record of the dressings done?

It was also argued that the first page of the doctor's order (AB VII) was a substituted page because it is 'of a different shade from pp 2–3' and is

'irreconcileable with other records', and that the word 'extended' which was written before the word 'fasciotomy' on AB VII had been a later inclusion because it is 'of a different handwriting and of a different ink.'

In response, the appellant had given his explanations to the discrepancies in the records. He said that he had performed the operative procedure that day in the casualty room. No anaesthetic was used because the patient's leg had no sensation. That is why the operation room's record did not show any record of the operation. He said his notes were scanty because in FH he was directly responsible for the patient and he did not have to write so that incoming doctor will know about it. He said he did the dressing himself in his clinic. That was why there was no record of any dressing done in the nurses' notes. With regards to the different ink and shade of the papers used, the appellant said that the notes were written both at his clinic and also at the ward. The shade of the papers used, depended on the stock used with those from his clinic being of a paler shade.

The trial judge had made a finding of fact that the fasciotomy was done on 12 September 1983, and not on 5 September 1983. It is established practice that an appellate court should be slow in disturbing the findings of the trial judge, unless the findings were based on the wrong facts or law. See *Dato Mokhtar bin Hashim & Anor v PP* [1983] 2 MLJ 232 at p 278. It is also trite law that an expert should not give an opinion on matters outside his field of expertise, see *PP v Lin Lian Chen* [1991] 1 MLJ 316. Clearly, the evidence of the medical experts regarding handwriting and authenticity of the records were not admissible evidence and should not have been accepted by the trial judge. A handwriting expert should have been called to determine the matter. As such, the learned sessions court judge was in error in making the above finding.

That being the case, I find that the assertion by the respondents that the appellant was negligent in delaying the performance of the fasciotomy is not sustainable. As such, the appellant should not have been found negligent for delaying the operative procedure.

Having said that, I propose to carry the discussion one step further in the event that this court is wrong in reversing the learned sessions court judge's finding. Even assuming that the inference was correctly drawn by the trial judge, the question still remains as to whether the appellant should be found liable for the plaintiff's damages. I propose to discuss this issue later in my judgment.

Treatment of the internal fixation

Further, it was contented that the appellant was, also negligent because he performed the internal fixation on the plaintiff's leg. The internal fixation, caused the leg to be infected, and this contributed to the plaintiff's injury. The appellant submitted that the decision to perform an internal fixation on the plaintiff's leg was a clinical decision that was taken in the interest of the plaintiff. He said there were four options that could have been taken to treat the fracture, namely:

(1) to treat the patient in plaster of paris back slab and dress wound;

(2) to put a skeletal traction in the calcaneum and dress the wound;

(3) to immobilize the fracture with an external fixator and dress the wound; and

(4) to open reduction and internal fixation. Leave wound open and dress the wound.

He further gave his reasons as to why he chose to do an open reduction and internal fixator.

There were differences in opinion by the expert witnesses as to the correct type of fixation that should have been done. The appellant's decision to do an internal fixation in the given circumstances was supported by his witness, Professor P Balasubramaniam, where he said:

> Internal fixation in this case carries advantages. Firstly, it gives a very good stable fixation of the fracture. Secondly, it allows for mobilization of the joint above and below fracture site and prevents joint stiffness. Thirdly, it allows for early discharge from hospital rather than a prolonged stay if other methods employed.

In *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, it was held that a doctor is not negligent if he is acting in accordance to a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of opinion that takes a contrary view. In *Kow Nam Seng*at p 130, the Federal Court applied the test and said:

> There may be differences of opinion as to the types of plaster casts to be applied in the treatment, of the type of injuries sustained by the respondent, but the choice of a treatment which is the standard medical practice, is not by itself a negligence.

In *Maynard v West Midlands RHA* (*HL*) [1984] WLR 634 the House of Lords held that at p 635:

> ... dismissing the appeal, that in the medical profession, as in others, there was room for differences of opinion and practice, and a court's preference of one body of opinion to another was no basis for a conclusion of negligence; that, accordingly, where it was alleged that a fully considered decision by two consultants in their own special field had been negligent, it was not sufficient to establish negligence for the plaintiff to show that there was a body of competent professional opinion that considered that the decision had been wrong, if there was also a body of professional opinion, equally competent, that supported the decision as having been reasonable in the circumstances.

Thus, applying the *Bolam* test, the decision by the appellant to do an internal fixation on the plaintiff's leg, by itself, is not negligent.

And so it remains to be considered whether, if the appellant had been negligent in the delay in performing the fasciotomy, should he be liable to contribute to the plaintiff's damages? In other words, it is left to be determined whether the appellant had caused the plaintiff's damage.

Causation

The claim for contribution is allowed under s 10 of the Civil Law Act 1956 where sub-s (c) reads:

> Any tortfeasor liable in respect of that damage may recover contribution from any other tortfeasor who is or would, if sued, have been liable in respect of the same damage, whether as a joint tortfeasor or otherwise, so, however thst no person shall be entitled to recover contribution under this section from any other person entitled to be indemnified by him in respect of the liability, in respect of which the contribution is sought.

In the fourth party proceedings the fourth party/respondents step into the shoes of the plaintiff. Thus, the onus is on the respondents to show that there is a causative link between the resultant damage and the negligent act of the appellant. This has to be proven on a balance of probabilities. This was exemplified in *Wilsher v Essex Area Health Authority* [1988] 1 All ER 871 where it was held at p 872:

> Where a plaintiff's injury was attributable to a number of possible causes, one of which was the defendant's negligence, the combination of the defendant's breach of duty and the plaintiff's injury did not give rise to a presumption that the defendant had caused the injury. Instead the burden remained on the plaintiff to prove the causative link between the defendant's negligence and his injury, although that link could legitimately be inferred from the evidence.

The law on causation as stated in *Jackson & Powell on Professional Negligence* (4th Ed) at p 719 is as follows:

> A plaintiff may claim that the defendant's negligent failure to give him proper treatment has deprived him of an improvement in his medical condition or has allowed him to deteriorate further. The 'but for' test of causation produces an 'all or nothing' result. Unless he can show that proper treatment was more likely than not to have produced an improvement or arrested the deterioration, the plaintiff will be unable to show that the defendant's negligence caused his damage and he will recover nothing. Thus, if the chance that proper treatment would have secured the desired result was less than 50%, the plaintiff cannot prove on a balance of probabilities that the damage would not have occurred in any event.

The onus and burden of proof therefore lies throughout on the respondents. They have the burden to prove that the appellant's negligent conduct has more probably than not, caused the damage to the plaintiff.

At the end of the trial, the learned sessions court judge concluded:

> Retracing all my findings earlier, I had before so doing considered all the possible explanations advanced by both the third and fourth party. I was satisfied that they had not acted and treated plaintiff in accordance with the accepted standard of approved medical practice to the extent as discussed earlier. The failure of the GH to maintain the circulation chart and to cut the POP had left the plaintiff with the case of fairly advanced ischaemic on discharge, which if properly attended to by the fourth party, would have saved his leg. The lack of care in Dr Siva's treatment as adumbrated earlier, had resulted in the amputation of plaintiff's leg. For both the third and fourth party's negligence, I find their contribution 60% and 40% respectively.

The learned sessions court judge apparently failed to direct his mind to the issue of causation. He concluded by finding both the respondents and appellant negligent and apportioned their liability at 60% for the respondents and 40% for the appellant. In the words of Lord Bridge in *Hotson v East Berkshire Area Health Authority* [1987] 2 All ER 909, 'a judge deciding disputed questions of fact will not ordinarily do it by use of a calculator'. However, the learned sessions judge's final apportionment of 40% liability on the appellant would have amounted to a conclusion that on a balance of probabilities the disabilities would have occurred anyway had the appellant provided the plaintiff with proper care.

As explained earlier, the learned trial judge has erred in failing to appreciate the true extent of the plaintiff's condition on arrival at FH. As such, if the appellant is found liable, his liability should have been apportioned lower. Having said that, taking this findings of the learned trial judge to be correct, it would still appear to amount to a conclusion that the respondents have failed to prove causation on a balance of probabilities. This apportionment of liability on the appellant would have meant that the respondents have failed to prove that the plaintiff would have recovered even if he had received proper treatment from the appellant.

This line of reasoning was taken in *Hotson*'s case where Lord Bridge at p 913 of the judgment, said:

> In some cases, perhaps particularly medical negligence cases, causation may be shrouded in mystery, that the court can only measure statistical chances. But that was not so here. On the evidence, there was a clear conflict as to what has caused the avascular necrosis. The authority's evidence was that the sole cause was the original traumatic injury to the hip. The plaintiff's evidence, as it's highest, was that the delay in treatment was a material contributory cause. This was a conflict, like any other about some relevant past event, which the judge could not avoid resolving on a balance of probabilities. Unless the plaintiff proved on a balance of probabilities that the delayed treatment was at least a material contributory cause of the avascular necrosis he failed on the issue of causation and no question of quantification would arise.

In that case, the plaintiff, who was 13 years old, was injured in a fall. He was taken to the defendant hospital where his injury was not correctly diagnosed. The true nature and extent of his injury was only discovered five days later. A severe medical condition had then developed which left the plaintiff with a permanent disability. On the facts, the trial court and the Court of Appeal found that there was a 25% chance of recovery if the plaintiff had received proper treatment and awarded damages representing 25% of the full loss to the plaintiff. This decision, however was reversed by the House of Lords at p 910 which held that:

> The crucial question of fact which the judge had had to determine was whether the cause of the plaintiff's injury was his fall or the health authority's negligence in making an incorrect diagnosis and delaying treatment, since if the fall had caused the injury the negligence of the authority was irrelevant in regard to the plaintiff's disability. That question was to be decided on a balance of probabilities. Accordingly since the judge had held that on the balance of probabilities, given the plaintiff's condition when he first arrived at

> the hospital, even correct diagnosis and treatment would not have prevented the disability from occurring, it followed that the plaintiff had failed, on the issue of causation, and the issue of quantification considered by the judge therefore never arose, because questions concerning the loss of a chance could not arise where there had been a positive finding that before the duty arose the damage complained of had already been sustained or had become inevitable.

In that case, in analyzing the issue of law arising from his findings, the trial judge said that in the end the problem came down to one of classification. He asked himself at p 921:

> Is this, on true analysis, a case where the plaintiff is concerned to establish causative negligence, or is it rather a case where the real question is the proper quantum of damage? Clearly the case hovers near the border.

He then reached a conclusion that the question was one of quantification and thus arrived at his apportionment of award of one quarter of the damages to the plaintiff.

At the House of Lords, Lord Ackner at p 921 had this to say:

> The learned judge thought, that the case 'hovers near the border'. To my mind, the first issue which the judge had to determine was an issue of causation: did the breach of duty cause the damage alleged? If it did not, as the judge so held, then no question of quantifying damage arises.

In the instant case, the learned sessions judge should have considered the issue of causation first before embarking on the other aspects of the case. To my mind, this appears to be a misdirection on his part. However, as explained earlier, even accepting the findings of the learned sessions judge, it would still have only amounted to a conclusion that the respondents have failed to prove its case on a balance of probabilities. That being the case, and in the light of the principles enunciated in *Hotson*'s case and the reasons given, the appellant should not have been found negligent and the issue of quantification of contribution should not have arisen.

It is thus the conclusion of this court that the appellant is absolved from all liability to the plaintiff and that the respondents are therefore fully responsible for the plaintiff's damages. The appellant's appeal is therefore allowed with costs herein and the court below, and the respondents are ordered to pay damages to the plaintiff at the agreed amount.

Appeal allowed.

Reported by Jafisah Jaafar